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IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON
ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Additional information submitted by States parties
to the Covenant following the consideration of
their reports by the Committee on Economic, Social
and Cultural Rights

Addendum

COLOMBIA */

[30 July 1990]

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*/ At the 12th-14th and 17th meetings of its fourth session, held from 23 to 25 January 1990 (E/C.12/1990/SR.12-14 and 17), the Committee considered the second periodic report of Colombia concerning rights covered in articles 10 to 12 of the Covenant (E/1986/4/Add.25).

By a note dated 30 July 1990, the Colombian Government submitted additional information which relates to the consideration of its report by the Committee and is reproduced in the present document.

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QUESTIONNAIRE PREPARED BY THE COMMITTEE ON ECONOMIC SOCIAL AND CULTURAL RIGHTS

1. How many doctors are there in Colombia per 10,000 inhabitants?

The country has 30,822 doctors for a total population of 29,264,469, or 10.53 doctors per 10,000 inhabitants.

2. Is there any Government policy to bring the purchase of medicine within the research of the economically underprivileged sectors?

The Government of Colombia is currently engaged in implementing a national medicine policy aimed at ensuring the timely supply of effective, safe and high-quality essential medicines to the entire population, especially the lower-income groups. This policy has been given special encouragement as part of the country's social policy.

Among the specific programmes, mention should be made of the community pharmacies, which have been receiving substantial economic support; the programme currently calls for 500 pharmacies, approximately 300 of which, covering 1,800,000 persons, are already in operation. Because of the source of the funding, the pharmacies are located in regions of extreme poverty and primary health-care institutions; the pharmacies are run entirely by the community and monitored and supervised by the Community Participation Committees, established through Decree No. 1216 of 1989, which governs community participation in health care.

The national medicine programme is considered to be of such importance that, as part of the restructuring of the National Health System, approved under Act No. 10 of 1990, the establishment of special funds for medicines is planned in each one of the 3,000 health service establishments; the Act also provides for the allocation of financial resources for improving the operation of the funds.

3. What have been the successes and hurdles met with as regards enjoyment of the right to health?

Recent Governments have developed social programmes under various names. Currently, the PNR (National Rehabilitation Plan) and EPA (Elimination of Absolute Poverty) Programmes are conducting interagency actions with various components - one of which is health - aimed at improving living standards by changing current inequalities in the provision of services.

In addition, the prevention, care and rehabilitation programmes conducted by the health system, such as the PAI (Extended Immunization Programme), SUPERVIVIR (National Plan for Infant Survival and Development), nutrition and supervision of minors, welfare hostels (part of the EPA and PNR), comprehensive senior citizen care, occupational health, physical rehabilitation, etc., and environmental programmes, such as basic sanitation, environmental conservation, food inspection and monitoring for animal-borne diseases, have helped to reduce morbidity and mortality, particularly in the mother and child group, and thus to raise the life expectancy of the population.

The hurdles met with as regards enjoyment of these rights derive from budgetary constraints, lack of access to services and poor management of available resources.

Finally, Act No. 10 of 1990 stipulates that health services are a public service and that basic health services, primarily preventive and primary health care, shall be provided free by the State.

4. What differences are there in the level of enjoyment of this right between urban and rural areas?

Social programmes, both people-oriented and environmental, are being developed and the above-mentioned Act is being implemented in both urban and rural areas. Nevertheless, despite the fact that marginal areas exist in our major cities, the quality of life in urban areas is higher than in rural areas.

Health services in rural areas, which basically involve primary health care, are hampered by geographical, economic and cultural isolation and lack of an appropriate reference and cross-reference system, all of which it is hoped to remedy by political and administrative decentralization. The urban areas are subject to such dangers as atmospheric pollution, high accident rates, stress and drug addiction, drug dependency and other civilization-related diseases.

5. Besides medical assistance through social security, what medical assistance is available to low-income women?

Health insurance in our country is not a service for low-income people. This type of medical assistance is a pre-paid service covering working people of various socio-economic levels and situations.

In 1975, the welfare services run by charitable or religious organizations, which basically covered low-income sectors, ceased to exist.

That year saw the introduction of the National Health System, under which 75 per cent of the population was eligible for direct public sector care, in primary, secondary and tertiary establishments; 15 per cent were covered by social security and 10 per cent by the private sector. In 1989 the actual number of people covered by the National Health System was 14 million.

On 10 January 1990, the Government passed Act No. 10, which declares health to be a public service; as a result, all health services are controlled by the State with regard to quality, guarantee of access by the population and rates. The State is also reorganizing the National Health System by decentralizing the administration of health services.

The new reform will make it possible to expand the sector's coverage to reach 90 per cent of Colombians, as follows: social security, 15 per cent of the population; equalization funds and other social security systems, 10 per cent; private medicine, 5 per cent; and 60 per cent for the hospital system financed from public resources, leaving without coverage 10 per cent, made up of scattered population groups to which access is difficult.

READEX FICHE

The Act stipulates that the Government shall establish a range of services to be offered free of charge to the entire population. For persons lacking means of subsistence or who need their health care to be provided for them, the Act stipulates that public health assistance shall be provided according to the conditions laid down in our Political Constitution.

Regulations are currently being established regarding the forms this assistance will take and who will be entitled to it.

6. What percentage of pregnant women receive prenatal care and deliver their children with qualified assistance?

Total health-care coverage for pregnant women (pre-natal consultations in all subsectors) in 1987: 90 per cent.

Total coverage of births in institutions (all sectors) in 1987: 70 per cent.

7. How does the Colombian Government handle the problem of abortion?

Abortion in Colombia is illegal and, under the Penal Code, anyone who performs an abortion, allows an abortion to be performed on her or induces a woman to have an abortion is guilty of a criminal offence.

From the health-care point of view, this is a problem, since the health services see only the complications resulting from abortions generally performed by back-street abortionists under non-sterile conditions.

In an attempt to solve this problem, the Mother-and-Child Care and Family Planning Programme encourages the family planning services to provide comprehensive care for adolescents in order to make birth control services accessible to this group, among which a high percentage of abortions occur.

8. What statistics are available on abortion?

- Birth/abortion ratio (institutional)

  1987 9/1

- Overall abortion rate

  1984 15.6 x 100,000

  Not verified.

The third highest cause of maternal death in Colombia in 1985 was "Unspecified abortion".

9. What type of co-ordination is there among the various drug-dependency treatment programmes?

In 1979, the Ministry of Health's Mental Health Division designed a basic subprogramme in the area, and a ministerial decision established State

services specialized in drug dependency and alcoholism, which are located in psychiatric hospitals and mental health units attached to general hospitals throughout the country.

Initially, the health sector focused on prevention, information, education, treatment and rehabilitation; subsequently, in 1985, it introduced a National Drug Addiction Prevention Plan, which provided that, given the variety of causes of drug addiction, various sectors should be involved in prevention activities, and set out to integrate and unite their efforts. Participants in the programme are the National Narcotics Board, which is its governing body, the Ministries of Justice, Agriculture, Health, Communications and Education, the Colombian Family Welfare Institute and the Colombian Institute for the Development of Higher Education.

These bodies undertake joint and co-ordinated action. There is a technical committee at the national level which meets periodically to evaluate and harmonize criteria; in addition, at sectional, regional and local levels, prevention committees have been formed, made up of representatives of these same institutions, who, in conformity with national policies and guidelines, conduct preventive and educational campaigns aimed at high-risk groups, specific groups such as parents, teachers, young people, etc., and at the population at large.

In particular, the Ministry of Health, through its Mental Health Division, is conducting a basic subprogramme on drug dependency and alcoholism, as part of its activities under the National Prevention Plan. As a result, care and treatment services for drug addicts have been strengthened; private institutions dealing with this problem and those concerned with prevention have been involved in this process, forming the "Network for the Treatment of Drug Dependency", with a view to offering various care alternatives or models.

10. It appears that, even in emergency cases, hospitals are prepared to grant medical help only if payment is secured within four days. Is the Government taking any steps to eliminate these practices?

In 1988, compulsory motor-vehicle insurance was introduced. It obliges insurance companies to transfer a specific amount of money to the hospitals' emergency network to cover treatment of traffic accident victims.

In Act No. 10 of 1990, the Government stipulated that emergency services must be provided to the entire population regardless of financial circumstances.

11. What percentage of pregnant women receive assistance under the Social Security programme?

Percentage of pregnancies in 1989:

$$\frac{\text{Pregnancies}}{\text{Members}} = \frac{\text{Births + abortions}}{\text{Members}}$$

$$\frac{124,533}{982,090} = 12.7\%$$

12. What percentage of employed women are affiliated with the Social Security programme?

Percentage of members in 1989:

$$\frac{\text{No. of members}}{\text{Total female wage-earning population. National total}} = \frac{982,090}{2,007,608\ (*)}$$

(*) Calculated on the basis of the 1985 population census.

13. What have been the successes and hurdles met with as regards enjoyment of the right to health?

The Social Security scheme in Colombia covers 15.8 per cent of the country's total population. It is represented by more than 190 national, departmental and municipal bodies.

Coverage is concentrated in the major urban centres, declining significantly in localities with fewer than 2,500 inhabitants.

The Social Security Institute, which is the most important of the country's social security institutions, protects the working population in the private sector, covering 49.8 per cent (3,874,801) of the total wage-earning population.

The present administration of the ISS decided to make the extension of coverage a priority. Taking the following form:

(a) Large-scale expansion. For the years 1990 to 1994, it is hoped to reach 367 municipalities, with a population of 1,175,069;

(b) Extension of family medicine to the cities of Bogotá, Medellín and Cali, representing an additional coverage of 2,417,032 persons.

The main difficulties in extending social security coverage stem from the nature of the Colombian Social Security system itself, which is oriented towards work-related social benefits and covers principally the formal sector working population and their families, under specific conditions, against the conventional risks of occupational and non-occupational illness, pregnancy, industrial accidents, disability, old age and death.

On a trial basis, the ISS has now introduced a health scheme for self-employed workers, directed at rural population groups. During the first half of the year, 2.05 per cent of the rural population of the municipalities of Algeciras, Timaná and San José de Isnos were enrolled and it is hoped to extend this to other Colombian municipalities.

14. Does Colombian law recognize the right to nurse of adoptive mothers?

Under the provisions of Act No. 24 of 24 January 1986, supplementing article 236 of chapter V of the Substantive Labour Code, and Act No. 69 of 19 December 1988 which sets out provisions for the protection of adoptive mothers employed by the public sector, Colombian law ensures that all provisions and guarantees applying to the biological mother also apply to the adoptive mother.

15. Does the law recognize a de facto union between two persons with legal capacity to enter into matrimony?

For all legal purposes, Colombian legislation does not expressly recognize de facto unions. However, guarantees are given to permanent partners who meet specific conditions, as may be seen in Decree No. 1160 of 2 June 1989, on pension replacement, or in the provisions concerning adoption, which authorize adoption for "a couple formed by a man and a woman who can prove that they have lived together without interruption for at least three years. If a previous matrimonial tie still exists for one or both of the persons forming the couple, this period shall be counted from the time of the judicial separation". (Decree No. 2737/89, Art. 90)

16. What actions are being taken to ensure greater compliance with child labour laws?

In Decree No. 2737 of 1989, the Minors' Code, which came into force on 1 March 1990, articles 237 to 264 set out the regulations for the protection of minors in employment. This statute derogates from Act No. 20 of 1982.

17. What are the criteria for determining which children are eligible for the Government-subsidized child care centres?

All children living in under privileged areas are eligible for the Welfare Hostel Programmes. The policy is aimed at reaching 100 per cent of children under seven in such areas.

18. At what stage is the joint programme with UNICEF dealing with the problem of street children?

The agreement between UNICEF and the Colombian Family Welfare Institute does not take into account the problem of street children.

TABLE No. 1

19. OCCUPIED PRIVATE DWELLINGS BY PUBLIC SERVICE CONNECTIONS

SERVICES AVAILABLE:

LEVEL	TOTAL	WATER SUPPLY, SEWERAGE AND POWER	WATER AND SEWERAGE	WATER AND POWER	SEWERAGE AND POWER	POWER ONLY	WATER ONLY	SEWERAGE ONLY	NO SERVICES
NATIONAL	5 251 273	2 982 483	44 590	531 065	71 540	534 602	141 699	23 246	922 048
ADMINISTRATIVE CENTRE	3 641 481	2 851 565	30 315	328 891	46 682	235 382	38 238	11 827	988 581
ELSEWHERE	1 609 792	130 918	14 275	202 174	24 858	299 220	103 461	11 419	823 467

It will be seen that, of the national total, 56.79 per cent of dwellings have all services and 17.5 per cent have none at all. In administrative centres, 78.3 per cent have all public services, while only 2.7 per cent have none. The rest, 1,609,792 dwellings, or 8.13 per cent, have water, sewerage and power connections.

As a result, if the national average of persons per dwelling is 5.2 and if a dwelling is assumed to be adequate if it has water, sewerage and power supply, we may conclude that 15,508,912 persons, or 55.65 per cent of the total estimated population of 27,867,326, are adequately housed.

However, on the basis of the three basic components of the quality of housing: structure, basic services and living space, assuming that during the period 1985-1990 there were no major variations in the breakdown by type of deficiency, the projections for 1988 show a shortage of housing in both qualitative and quantitative terms.

TABLE No. 2

BREAKDOWN OF THE HOUSING SHORTAGE

ALL DEPARTMENTS - PROJECTED TO 1988

TYPE OF DEFICIENCY	UNITS	PERCENTAGES
INADEQUATE LIVING SPACE ONLY	628 599	34.57
INADEQUATE SERVICES ONLY	689 355	37.91
INADEQUATE SPACE AND SERVICES	319 422	17.57
INADEQUATE STRUCTURE ONLY	29 329	1.61
INADEQUATE STRUCTURE AND SPACE	30 322	1.67
INADEQUATE STRUCTURE AND SERVICES	59 132	3.25
INADEQUATE STRUCTURE, SPACE AND SERVICES	62 313	3.43
TOTAL	1 818 472	100.0

Source: DANE-COLCIENCIAS: "Compilation and analysis of housing data for 1985", updated to 1988.

20. What is the average number of persons occupying a dwelling?

As mentioned above, the average number of persons per dwelling is 5.2 at the national level, ranging from 5.1 in administrative centres to 5.5 elsewhere.

21. What is the housing situation in rural areas?

If "elsewhere" is taken to mean rural areas, the situation is as follows:

TYPE OF HOUSING	No.	AVERAGE NUMBER OF PERSONS PER DWELLING
HOUSE	1 839 753	5.5
APARTMENT	20 281	4.1
OTHER	8 790	4.5
TOTAL		3 641 481
WATER, SEWERAGE AND POWER		2 851 565
WATER AND POWER		328 891
SEWERAGE AND POWER		46 682
POWER ONLY		235 382
WATER ONLY		38 238
SEWERAGE ONLY		11 827
NO SERVICES		98 581

BY PREDOMINANT WALL MATERIAL

TOTAL	3 641 481
BRICK BLOCKS AND ADOBE	3 204 970
WATTLE AND DAUB	242 294
BAMBOO OR REEDS	38 987
WOOD	133 763
CANVAS OR SCRAP MATERIAL	20 022
NO WALLS	1 445

BY PREDOMINANT FLOOR MATERIAL

TOTAL	3 641 481
WOOD	549 911
TILES	2 848 241
EARTH	243 329

The estimated rural housing deficit, for the year 1986, is 1,164,276 units including 264,276 to be built and 900,000 to be improved. Of the latter, 799,793 are typically shacks, huts or hovels with earth floors, and no sanitation or drinking water, and representing an under-privileged situation in socio-economic terms.

22. What is the housing situation of indigenous groups?

The indigenous population numbers 237,759 persons with 48,037 dwellings, which have the following characteristics:

BY PREDOMINANT WALL MATERIAL

TOTAL	48 037
BRICK BLOCKS, ADOBE OR PLASTERED MUD	8 950
WATTLE AND DAUB, CANE OR REEDS	29 893
WOOD	6 078
OTHER	2 400
NOT KNOWN	716

BY PREDOMINANT ROOF MATERIAL

TOTAL	48 037
MUD ROOF	22 583
STRAW	21 278
OTHER	3 460
NOT KNOWN	716

BY CLASS OF SANITATION

TOTAL	48 037
TOILET CONNECTED TO SEWERAGE SYSTEM	2 132
TOILET CONNECTED TO A SEPTIC TANK	3 201
LATRINE	6 245
NO SANITATION	36 459

23. Why do the housing programmes listed under the Plan for the Elimination of Absolute Poverty concentrate on urban housing?

In this regard, the scale of rural migration and consequently the proliferation of marginal settlements in major cities should be borne in mind; these are phenomena which have in turn inverted the distribution and structure of the urban and rural population, with the urban population rising from 30 per cent to 70 per cent and the rural population decreasing to a similar degree. This has led to an predominantly urban society, thus explaining the fact that the housing shortage is concentrated in the cities.

From an economic point of view, the construction sector has played an important role in generating employment, and this has contributed to the adoption of housing policies. In addition, the scattered nature of rural housing means that it requires more economic and infrastructural resources, a restricting factor in the development of mass building and rehabilitation programmes for rural housing.

However, bodies such as the Agrarian Fund, the DRI-Incora Fund and the National Federation of Coffee Growers earmark regular if not adequate resources, for rural housing development.

24. What is being done about the large squatter settlements located on the outskirts of Bogotá?

In 1989, the Institute made investments of 3,034.9 million pesos and the Cundinamarca regional government has a budget of 2,126.6 million pesos for 1990, of which 1,126.2 million are earmarked for projects located in Bogotá.

Projects involving 4,279 units were being implemented in 1989.

25. What repercussions have the activities of guerrilla and terrorist groups and drug traffickers in Colombia had on the enjoyment of the right to an adequate standard of living, health, education, etc?

The presence and activities of guerrilla and terrorist groups and drug traffickers naturally have negative repercussions on society's right to an adequate standard of living.

Firstly, it clearly impairs the unrestricted enjoyment of the most elementary and basic of rights, the right to life, and specifically in the case of the activities of guerrilla groups, the right to life of the peasant population and of the population in deprived rural areas. The activities of terrorist groups and drug traffickers also have a particularly negative effect on the enjoyment of this right among the urban population. Secondly, such activities also have negative repercussions on the right to an adequate standard of living, since their aim is the destruction of the infrastructure which ensures the provision of the basic services such as security, education, health, banking services, etc. Finally, such activities restrict freedom of expression and the exercise of such basic rights as freedom of movement and, in some instances, the right to vote freely.

26. What were the criteria for selecting the areas to benefit from the National Rehabilitation Plan (PNR)?

The PNR is intended to benefit individuals, areas and activities which have thus far suffered constantly from poverty and have not participated in Colombia's economic and social progress. The Plan is also intended to create development opportunities in areas where economic dislocation, an institutional vacuum and the level of poverty have fostered social imbalances which often manifest themselves as conflicts that are dealt with through non-institutional channels.

Accordingly the Government is promoting change through the rehabilitation of populations and areas afflicted by violence, the normalization of urban life and the reconciliation of Colombians with one another. The aim is to establish closer links between the State and the needs of individuals, so as to integrate them politically, socially and economically with the rest of the country, and thus create a just society as a basis for democracy and peaceful coexistence.

The Plan thus reflects the political will of the State to become involved in the solution of the community's problems and providing for its basic needs, so as to strengthen the people's confidence in the civil authorities and institutional action.

The Plan comprises elements designed to deal with the situation of social emergency prevailing in those areas. However, its main focus is on programmes for strengthening local and regional economic activities in which the population participates and from which it hopes to benefit. The production sector support programmes to be implemented from 1987 onwards involve basically improving the road system (main highways and local roads), the physical infrastructure (water supply, sewerage, power supply) credit facilities and the transfer of technology for agricultural and agro-industrial production, consolidating marketing systems, implementing agrarian programmes and establishing integrated settlement districts. Other programmes will have a social objective, such as community training, support for municipal management and investment in the health and education sectors.

The Plan's strategy is not to provide goods and services to the community on a large scale, but rather to create the minimum conditions to enable communities to embark on self-development, on the basis of the fundamental right of individuals to participate in the decisions affecting them, with the support of the State. Community involvement, the opening up of institutional channels to make such involvement feasible and joint State-community action are thus corner-stones of this strategy.

On the basis of the above criteria, the PNR covers a total of 304 municipalities. Areas have therefore been classified, according to their common development characteristics, as settlement, depressed or inaccessible regions. Since the reasons for their exclusion from national development differ in each case, objectives, strategies and policies are adjusted to the specific characteristics of each region.

The criteria for including municipalities in the coverage of PNR were therefore the following:

Socio-economic situation: account is taken at least of the size of the population, mortality and birth rates, agrarian structure and land use, type and volume of production and marketing possibilities, road infrastructure and, in general, the location of municipalities on the poverty map;

Institutional infrastructure: account is taken of the coverage, quality and conditions governing the provision of such services as water supply, sewerage, education, health and power supply, the lack of which frequently gives rise to protest movements;

Funding possibilities: this means the actual availability of national and regional resources in the form of specific appropriations and pledges.

The regionalization of the Plan is thus relative and flexible: relative in that the areas covered by the Plan can vary according to the extent of the dislocation of the economic, social and political processes on which the population depends; flexible in that the interrelationship between the various

factors affecting stability and regional coexistence generate processes whose repercussions extend beyond the boundaries of the political and administrative units into which the country is divided.

27. Which extremely impoverished regions were not included in the National Rehabilitation Plan?

The regions which were not included in the PNR and whose communities have requested inclusion are the following:

- Department of Nariño:

  Pacific coast: Municipalities of El Charco, Iscuande, Bocas de Satinga, Pizarro, Mosquera, Magui, Sala Honda, Roberto Payan, Barbacoas, El Carmen, Puerto Merizalde, Santa Barbara;

  North: La Union-San Pablo, San Jose de Alban.

- Department of Cauca:

  Pacific coast: Lopez de Micay, Timbiqui, Guapi.

- Department of Huila:

  Municipalities: Oporapa, Salado Blanco, Elias, Isnos, La Argentina. Timaná.

- Comissariat of Guainia

- Department of Guajira:

  All municipalities, including those receiving coal royalties.

- Department of Norte de Santander:

  Pamplonita, Cucutilla, Bochatema, Arboledas, Salazar, Gramalote, Santiago, San Cayetano, Los Patios, Ragombolia, Cacota.

- Department of Tolima:

  San Antonio, Roncesvalle (administrative centre).

- Department of Magdalena:

  The municipalities in the south of the department.

- Department of Cesar:

  Municipalities of Zapotosa, Pailitas, Chimichagua, Tamelameque, Saloa.

- Department of Caldas:

  Riosucio, Marmato and Supia.

- Department of Santander:

  Province of Garcia Rovira, Cerrito, San José de Miranda, San Andres, Guaca, Enciso, Concepción, Carcasi, San Miguel.

28. How is the indigenous population affected by the problems of political violence?

Indigenous communities represent about 2 per cent of the total Colombian population. They are spread throughout the length and breadth of the country: 40 per cent in the Andean areas and 60 per cent in the savannah and forest areas.

It can be stated at the outset that the indigenous populations are the groups least affected by the political violence.

Of the persons reported to have died as a result of acts of political or presumed political violence during 1988 and 1989, 1.23 per cent and 1.17 per cent respectively were members of indigenous groups.

There are a number of reasons for these low figures.

Geographical location, since most of them are in areas not involved in violent political conflicts;

Even those in areas where violence is prevalent have managed to remain outside the conflicts (Sierra Nevada, Urabá);

Their small numbers compared to the national population.

However, an analysis of the violence affecting the indigenous communities shows that, while the number of deaths among indigenous communities is neglible in national terms, it is significant in terms of the indigenous populations itself.

Acts of violence against indigenous persons occur mainly in areas marked by guerrilla activity, armed conflict and/or land recovery campaigns.

The areas most affected are the departments of Cauca, Córdoba and Caldas, where there are armed groups and land recovery proceedings are in progress.

The indigenous populations in these areas are victims of groups which, for various reasons, see the organization and mobilization of indigenous populations as a threat to their own interests. Consequently, there are a number of possible causes for the deaths reported, including:

Executions of indigenous persons by guerrillas, either to force the community to co-operate with them, or because the individuals concerned were suspected of collaborating with the army;

In the Department of Cauca in 1989 alone, the pro-indigenous guerrilla group known as "Comando Armado Quintín Lame" is thought to have been responsible for 15 per cent of the murders of indigenous persons or persons connected with them;

Acts of private paramilitary vigilante groups against indigenous persons, principally indigenous leaders involved in land recovery proceedings (Cauca, Córdoba);

Acts of private paramilitary vigilante groups against indigenous leaders involved in organizing communities to strengthen their demands for respect for their rights, and against leaders conducting successful regional electoral campaigns (Caldas);

Indigenous persons killed in the course of armed clashes between the army and guerrillas.

While the three areas mentioned are those with the highest incidence of indigenous deaths, there are other areas of the country where communities are severely affected by the presence of guerrilla and paramilitary groups which, while it may not have resulted in fatalities, has impeded and, in many cases, restricted the ability of communities to organize. These groups have also exerted pressure on indigenous communities to ensure that their campaigns and demands fit in with their own political interests.

It should be noted that this type of pressure occurs not only in communities with long organizational experience, but also, and principally, in highly traditional communities with little experience of negotiating with the Government.

In this regard, as part of the National Rehabilitation Plan, the Government of Colombia is promoting a series of actions aimed basically at strengthening indigenous communities and their authorities, ensuring respect for their rights and independence and improving their socio-economic conditions, all as part of a policy of community participation.

Among the measures taken are the following:

The handing over of vast tracts of land to indigenous communities, where they have established traditional settlements;

The formation and launching of various indigenous consultative and decision-making bodies to provide guidelines for action by State institutions;

An education programme on the rights of indigenous communities, including courses in indigenous law and human rights for civil and military authorities in areas inhabited by indigenous communities.

In addition, simple law handbooks have been produced explaining to indigenous communities how to lodge complaints of violations of their fundamental rights.

29. What is the relationship between the National Rehabilitation Plan and the Plan for the Elimination of Absolute Poverty?

The National Rehabilitation Plan, the Plan for the Elimination of Absolute Poverty and the Comprehensive Rural Development Plan all form part of the strategy formulated by the Government of President Virgilio Barco Vargas, under the Plan for the Social Economy as an alternative solution to the most serious problems of the marginalized and underprivileged population groups in Colombia.

In each case, the aim is to set up machinery to generate stable incomes and provide basic services to the population. In addition, by being encouraged to participate in the discussion, management and solution of their own problems, with Government assistance and participation, the communities are gradually making the transition from representative and limited democracy to participatory democracy. To this end, each programme has created and set in motion machinery providing organized local communities with a physical and political meeting point, and also with direct access to the Government, thus facilitating reconciliation between Government and people.

In short, although the PNR and the Plan for the Elimination of Absolute Poverty are designed to benefit different social groups - in the first case the rural population and, in the second, the urban population - both are corner-stones of the current economic and social programme.

30. Has the migration phenomenon been taken into account in the Rehabilitation and Normalization Plans?

In so far as one of the basic strategies of the National Rehabilitation Plan is aimed at the populations in settlement areas, the migration phenomenon can be said to have been taken into account. A characteristic of these areas is that they have given refuge to a numerically significant population group which, for various reasons (modernization of agriculture, political violence, inability of urban industry to absorb surplus manpower, etc.), has had to leave its natural and original home for other areas in order to make a living.